

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/31/2012
NAME OF PROVIDER OR SUPPLIER WILLIAM N WISHARD MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W 10TH ST INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of 2 (two) State hospital complaint investigations.</p> <p>Complaint: #IN00098997 Unsubstantiated; lack of sufficient evidence.</p> <p>Complaint: #IN00093578 Unsubstantiated; lack of sufficient evidence.</p> <p>Facility: #005023</p> <p>Date: 12-20/21-11 and 01/31/12</p> <p>Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor</p> <p>William N. Wishard Memorial Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: claughlin 04/02/12</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1